



**KENTUCKY BOARD OF  
EMERGENCY MEDICAL SERVICES**

COMMONWEALTH OF KENTUCKY  
2545 LAWRENCEBURG ROAD  
FRANKFORT, KENTUCKY 40601  
PHONE: 502-564-8963  
FAX: 502-564-4687



**EMS-TEI PARAMEDIC TRAINING PROGRAM**  
**VERIFICATION FORM**

This form completes requirement number 8 on the Paramedic Initial Licensure Requirements Checklist.

All students must:

*Successfully complete, within thirty (30) months of the beginning of the course, all EMS-TEI requirements for the education or training program which:*

- a. Utilize the United States Department of Transportation, National Highway Traffic Safety Administration, 1998 National Standard Curriculum for Emergency Medical Technician-Paramedic, which shall not be satisfied by the completion of refresher or transition courses alone; and*
- b. Shall not contain less than the ~~median~~ mean number of didactic, practical laboratory, and clinical and field internship hours for each subject and skill as contained in the "Field and Pilot Test Didactic and Practical Laboratory Hours Report" and "Field and Pilot Test Clinical Report" of the United States Department of Transportation, National Highway Traffic Administration, 1998 National Standard Curriculum for Emergency Medical Technician-Paramedic;*

Date of Report: \_\_\_\_\_

Name of Training and Educational Institution: \_\_\_\_\_

Course Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - P

The location for this course: \_\_\_\_\_

Course Starting Date: \_\_\_\_\_

Course Ending Date: \_\_\_\_\_

Paramedic Student Name: \_\_\_\_\_  
*Last, First Middle*

Paramedic Student Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

### **STUDENT VERIFICATION SECTION**

I, \_\_\_\_\_, hereby certify that I have completed (at least)  
*Printed name of Paramedic Student*  
347.88 Field Internship hours, (at least) 75 patient contacts and (at least) 118.40 Field Summative  
Evaluation hours for a total of at least 466.28 hours.

\_\_\_\_\_  
*Signature of Paramedic Student*

\_\_\_\_\_  
*Date*

### **MEDICAL DIRECTOR & INSTRUCTOR VERIFICATION SECTION**

I, \_\_\_\_\_, hereby certify that the above student has  
*Printed name of Medical Director*  
completed (at least) 347.88 Field Internship hours, (at least) 75 patient contacts and (at least)  
118.40 Field Summative Evaluation hours for a total of at least 466.28 hours.

\_\_\_\_\_  
*Signature of Medical Director*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of Paramedic Course Lead Instructor*

\_\_\_\_\_  
*Date*

Instructor Name: \_\_\_\_\_

Instructor Certification Number: \_\_\_\_\_

Instructor Phone Number: \_\_\_\_\_

Instructor Email Address: \_\_\_\_\_

(To be submitted to KBEMS by the educational institution upon completion of Field hours)